INSURANCE DIVISION
HEALTH INSURANCE BRANCH
STATE OF HAWAII

CLEAR FORM

P.O. Box 3614
Honolulu, Hawaii 96811
Telephone (808) 586-2804

HEALTH COMPLAINT/INQUIRY FORM

ASSISTANCE IS NEEDED CONCERNING: ☐ A Complaint ☐ An Inquiry

PLEASE PRINT OR TYPE:

_____ Your Name

_____ Address

_____ City, State, Zip Code

_____/_____ Res./ Bus. Telephone Number

_____/_____ Mobile/Pager Telephone Number

_____ e-mail address

_____ Name of Insurer/Health Plan/ Individual Involved

_____ Address

_____ City, State, Zip Code

_____ Telephone Number

Please indicate policy, member, and/or claim number, if known:

_____

STATE THE RELIEF SOUGHT: _____

_____

_____

STATE A SUMMARY OF COMPLAINT/INQUIRY. INCLUDE (1) ALL INFORMATION YOU BELIEVE TO BE RELEVANT TO YOUR CLAIM AND (2) THE ISSUES OF CONCERN:

_____

_____

_____

_____

(Continuation of Summary of Complaint/Inquiry)

ATTACH COPIES OF PERTINENT DOCUMENTS. **DO NOT SEND ORIGINALS.**

NOTICE: A copy of this form may be sent to the insurance company And/or individual involved.

Your Signature _____ Date _____